HOSPITALITY EYECARE
CENTER of OPTOMETRY

ph 909 383 5000
fx 909 383 5010

164 W Hospitality Lane, Suite 7
San Bernardino, CA 92408

www.SeeToLive.com

EYECARE REGISTRATION AND HISTORY

PATIENT INFORMATION

Date _____

Patient _____

Address _____

_____

City State Zip

Email _____

Sex: [ ] M [ ] F Age _____ Birthdate _____

Patient SS# _____

Occupation _____

Employer _____

Employer Phone # _____

Employer Address _____

Spouse's Name _____

Birthdate _____ SS# _____

Occupation _____

Spouse's Employer _____

Whom may we thank for referring you? _____

_____

INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional Insurance? [ ] Yes [ ] No

Subscriber Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____and assign directly to Hospitality Eyecare Center all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature _____

Relationship _____ Date _____

PHONE NUMBERS

Home _____ Work _____ Ext. _____ Spouse's Work _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name _____Relationship _____

Home Phone _____Work Phone _____

MEDICATIONS

List medications you are currently taking, including eye drops, over the counter medications & herbs:

_____

_____

_____

Pharmacy Name _____

Phone _____

ALLERGIES

List your allergies to medication or other substances:

_____

_____

_____

_____

_____

_____

HEALTH HISTORY

Physician's Name _____ Date of last visit _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following. Also place a mark to indicate if a blood relative has had any of the following.

	Yourself	Family Members		Yourself	Family Members
AIDS/HIV	[ ] Yes [ ]No	[ ] Yes [ ]No	Hepatitis (Type _____)	[ ] Yes [ ]No	[ ] Yes [ ]No
Arthritis	[ ] Yes [ ]No	[ ] Yes [ ]No	High Blood Pressure	[ ] Yes [ ]No	[ ] Yes [ ]No
Artificial Heart Valve	[ ] Yes [ ]No	[ ] Yes [ ]No	Kidney Disease	[ ] Yes [ ]No	[ ] Yes [ ]No
Artificial Joints	[ ] Yes [ ]No	[ ] Yes [ ]No	Lazy Eye	[ ] Yes [ ]No	[ ] Yes [ ]No
Asthma	[ ] Yes [ ]No	[ ] Yes [ ]No	Lupus	[ ] Yes [ ]No	[ ] Yes [ ]No
Bleeding	[ ] Yes [ ]No	[ ] Yes [ ]No	Migraine Headaches	[ ] Yes [ ]No	[ ] Yes [ ]No
Blindness	[ ] Yes [ ]No	[ ] Yes [ ]No	Pacemaker	[ ] Yes [ ]No	[ ] Yes [ ]No
Cancer	[ ] Yes [ ]No	[ ] Yes [ ]No	Poor Color Vision	[ ] Yes [ ]No	[ ] Yes [ ]No
Cataracts	[ ] Yes [ ]No	[ ] Yes [ ]No	Retinal Disease	[ ] Yes [ ]No	[ ] Yes [ ]No
Chemical Dependency	[ ] Yes [ ]No	[ ] Yes [ ]No	Rheumatic Fever	[ ] Yes [ ]No	[ ] Yes [ ]No
Diabetes	[ ] Yes [ ]No	[ ] Yes [ ]No	Shingles	[ ] Yes [ ]No	[ ] Yes [ ]No
Drug Sensitivity	[ ] Yes [ ]No	[ ] Yes [ ]No	Skin Conditions	[ ] Yes [ ]No	[ ] Yes [ ]No
Emphysema	[ ] Yes [ ]No	[ ] Yes [ ]No	Stroke	[ ] Yes [ ]No	[ ] Yes [ ]No
Epilepsy	[ ] Yes [ ]No	[ ] Yes [ ]No	Thyroid Conditions	[ ] Yes [ ]No	[ ] Yes [ ]No
Eye Surgery	[ ] Yes [ ]No	[ ] Yes [ ]No	Tuberculosis	[ ] Yes [ ]No	[ ] Yes [ ]No
Glaucoma	[ ] Yes [ ]No	[ ] Yes [ ]No	Turned Eye	[ ] Yes [ ]No	[ ] Yes [ ]No
Hay Fever	[ ] Yes [ ]No	[ ] Yes [ ]No	Are you pregnant? _____	Number of Children _____	
Heart Condition	[ ] Yes [ ]No	[ ] Yes [ ]No	Tobacco use _____	Alcohol use _____	

EYE HEALTH HISTORY: experiencing any of the following?

Do you use a computer more than 30 minutes a day? [ ] Yes [ ] No

Do you wear sunglasses with UV protection? [ ] Yes [ ] No

Are you interested in Contact Lenses? [ ] Yes [ ] No

Are you interested in Lasik? [ ] Yes [ ] No

Place a Mark on "Yes" or "No" to indicate if you have had any of the following:

Bloodshot Eyes	[ ] Yes [ ]No	Floaters or Spots	[ ] Yes [ ]No
Blurred Vision - Distance	[ ] Yes [ ]No	Glaucoma	[ ] Yes [ ]No
Blurred Vision - Near	[ ] Yes [ ]No	Headaches	[ ] Yes [ ]No
Burning Eyes	[ ] Yes [ ]No	Itching Eyes	[ ] Yes [ ]No
Cataracts	[ ] Yes [ ]No	Light Sensitivity	[ ] Yes [ ]No
Poor Color Vision	[ ] Yes [ ]No	Loss of Vision	[ ] Yes [ ]No
Crossed Eyes	[ ] Yes [ ]No	Migraine Headaches	[ ] Yes [ ]No
Discharge from Eyes	[ ] Yes [ ]No	Poor Night Vision	[ ] Yes [ ]No
Dizzy Spells	[ ] Yes [ ]No	Red Eyes	[ ] Yes [ ]No
Double Vision	[ ] Yes [ ]No	Seeing Halos	[ ] Yes [ ]No
Dry Eyes	[ ] Yes [ ]No	Seeing Flashes	[ ] Yes [ ]No
Eye infection	[ ] Yes [ ]No	Temporary Loss of Vision	[ ] Yes [ ]No
Eye injury	[ ] Yes [ ]No	Twitching Eyelid	[ ] Yes [ ]No

Thank you for providing this information. It helps me provide optimal eye health and vision care for you!
Dr. Cynthia Corbett

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PATIENT ACKNOWLEDGMENT

Acknowledgment Receipt of Notice of Privacy Practices

By signing this form, you acknowledge receipt of the Notice of Privacy Practices of this entity. Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information. We strongly encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by accessing our web site at www.SeeToLive.com or contacting our office at:

Hospitality Eyecare Center of Optometry

164 W. Hospitality Lane, Suite 7
San Bernardino, CA 92408
909.383.5000
Info@SeeToLive.com

Signature of patient/legal representative:_____
Date/Time:_____

INABILITY TO OBTAIN PATIENT ACKNOWLEDGMENT

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

☐ Individual refused to sign

☐ An emergency situation prevented us from obtaining acknowledgment , and an attempt to obtain the acknowledgment will be made at the next available opportunity.

☐ Patient incapacitated/ unable to sign

☐ Other (Please specify)

Patent Name:_____
Patient social security number_____
Signature of Facility Representative:_____
Date/Time:_____

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Ocular Emergency Report Form

Patient Name_____Date_____
Phone Number_____

Current Problem_____

Are you experiencing any of the following?

_____ Flashing lights
_____ Loss of vision
_____ Curtain/veil blocking vision
_____ Different-sized pupils
_____ Foreign object in eye
_____ Floaters
_____ Pain
_____ Chemical in eye
_____ Double vision

Which eye is affected? Right_____ Left_____ Both_____

When did it start?_____

Have you had any recent injury to your head or neck area?_____

Has the current problem been getting better or worse?_____

Has it ever happened before?_____

Are you wearing contact lenses now? No_____ Yes_____ If yes, remove immediately.

Have you slept with your contacts in? No_____ Yes_____ If yes, when?_____

Type of contacts: Soft_____ Daily wear_____ Extended wear_____ Gas permeable_____

Continued

Are You Experiencing:

Redness? No_____ Yes_____
If yes, describe where it is on the eye_____

Decreased vision? No_____ Yes_____
If yes, describe if sudden or gradual, blurry, distorted or missing_____

Pain? No_____ Yes_____
If yes, describe the pain_____

Sensitivity to light? No_____ Yes_____
If yes, describe_____

Double vision? No_____ Yes_____
If yes, describe_____

Pupils different size? No_____ Yes_____
If yes, describe_____

Burning sensation? No_____ Yes_____
If yes, describe_____

Itching? No_____ Yes_____
If yes, describe_____

Tearing? No_____ Yes_____
If yes, describe_____

Discharge or mucus in eye? No_____ Yes_____
If yes, describe_____

The sensation that something is in your eye? No_____ Yes_____
If yes, describe_____

Swollen eyelids? No_____ Yes_____
If yes, describe_____

What have you done to help (eye drops, eyewash, emergency department)?

_____

_____